Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z9999	FINDINGS	Z9999		

Statement of Licensure Violations:

350.620a)
350.1210
350.3240a)
350.3240d)

Section 350.620 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually.

Section 350.1210 Health Services

The facility shall provide all services necessary to maintain each resident in good physical health.

Section 350.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department. (Section 3-610 of the Act)

These Regulations were not met as evidenced by:

Based on record review, observation, and

Attachment A
Statement of Licensure Violations

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Z9999	Continued From page 1 interview, the facility failed to follow their policy to prevent abuse and neglect, affecting 7 of 7 clients out of the sample,(R11, R12, R15, R27, R37) when the facility failed to: 1. Provide sufficient supervision for 1 of 1 client with a known history of PICA (R11), who ingested inedible objects on 10-6-15 and 10-7-15. 2. Ensure staff implement their policy to prevent abuse and neglect for 1 of 1 clients who sustained a fractured toe (R12) after being bitten by R11, on 7/17/15. 3. Ensure that facility implement safeguards by tracking trends and patterns after R11 was involved an incident where the other resident was injured. R12 sustained a fractured toe on 7/17/15. 4. Ensure that facility implemented safeguards for 1 of 1 client (R37) with a scrotal laceration. 5. Ensure that facility implement safeguards for 1 of 1 client (R27) with eight fall incidents. Findings include: The Facility's Incident / Accident Report, dated 5-29-14, is written as follows: The incident accident report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident to resident altercations. An incident is defined as any happening not consistent with the routine operation of the facility, that does not result in bodily or property damage. Physical or mental mistreatment (abuse - actual or	Z9999		

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Z9999	Continued From page 2 suspected) of a resident is considered an incident whether or not actual injury has occurred. An accident is defined as any happening not consistent with the routine operation of the facility that results in bodily injury other than abuse. An incident/ accident report will be completed for all serious accidents or incidents of residents. All unusual occurrences. All situations requiring the emergency services of a hospital. Any type of resident abuse. All unexpected events that occur that cause actual or potential harm to a resident or employee. Any condition resulting from an accident requiring first aid, physician visit, or transfer to another health care facility. All incident / accident reports are reviewed, signed, and investigated by the administrator who also verifies that a thorough investigation has been completed and necessary changes if any are made to prevent reoccurrence. According to the Policy and Procedure Manual, given to surveyor on the date of 10-5-15, to assure that persons with disabilities are served in a manner that allows them from fear of abuse or neglect. The facility accepts zero tolerance for abuse and neglect. If an investigation based on credible evidence reveals that injury to a program participant has been inflicted by another program participant, the injured party's protection is a priority. The investigator team must evaluate the need to temporarily or permanently separate the individuals and develop a plan for the long term decreased likelihood of another injury. A behavior development program, counseling, drug therapy, psychiatric hospitalization, relaxation training and other therapies may be attempted to avoid reoccurrence. All persons having knowledge relating to the alleged abuse or neglect should provide written statements.	Z9999		

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Z9999	Continued From page 3 Interviews may be completed to provide more information or detail. All other forms of evidence will be collected for review. The full investigative report includes the following as applicable: incident report, injury report, photographs, witnesses written statements, medical reports, diagrams of the location of the incident, summary of the finding. The incident review committee, a standing staff committee reviews all incidents and injuries. This committee makes recommendations as to patterns of incidents by program, program participant, or by specific staff member. It also monitors incidents involving injuries with unknown cause to assure that they have not been due to abuse or neglect. The definition of abuse is any physical injury, sexual abuse, or mental injury inflicted on an individual other than by accidental means. The definition of allegation is any assertion, complaint, suspicion or incident when abuse or neglect of individuals may have occurred. The definition of neglect is the failure to provide adequate medical or personal care or maintenance, which failure results in physical or mental injury to an individual or in the deterioration of an individual's physical or mental condition. The definition of physical injury is physical harm to an individual caused by any non accidental act or omission. The definition of serious injury is an injury that requires medical treatment. 1) Per record review of the Physician Order Sheet dated 9-15-15 to 10-14-15, R11 is a 31 year old male who functions in the Profound Range of Intellectual Disability. R11's diagnoses includes Cerebral Palsy, PICA (ingesting inedible objects), and Spastic Quadriplegia.	Z9999		

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Z9999	Continued From page 4 Per the Annual Program Review dated 6-25-13, the following is an integrated summary of R11's major life areas. R11 does not speak so it can be difficult to engage in interpersonal and social interactions. R11 depends on staff observation of changes in mood or activity level to notice physical symptoms and to report them to the clinical staff so that he may obtain care in a timely manner if needed. He utilizes a wheelchair in which he can self propel if the flooring is right. R11 is at high risk for choking because he likes to put small objects in his mouth including chewing pieces off his shirts and tearing small pieces off his adult diaper. R11 has a habit of grabbing other peoples food and needs to be monitored for this at all mealtimes. The behavior domains currently being addressed for R11's behavior intervention plan is for his self injurious behavior. R11 will wheel himself from one area of the home to a desired area to communicate when he wants something. Staff should offer R11 close supervision at all times. Per the Annual Assessment dated 1-14-15, R11 displays some behaviors consisting of biting his hand, chewing on clothing, or attempting to shred items that are soft or mouthing them. He may also steal food from other residents and requires careful monitoring during meals. Staff who work with him report that he responds well to verbal redirection. Per the Program Memo dated 2-1-15, R11 has known behaviors of eating too fast and he has PICA therefore R11 must be carefully monitored at all meals to decrease the risk of him stuffing his mouth and potentially choking. Monitor him during activities involving small objects, etc. to reduce the risk of PICA. Report immediately to nursing any vomiting or any observed or	Z9999		

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Z9999	Continued From page 5 suspected incidents of PICA. Per record review of the nursing notes the only suspected incidents for R11 were on 7-6-15 and 7-17-15. Per record review of the Program Memo dated 2-1-15, R11 has been known to stick objects far up in his nose, and he also puts his fingers in his nose. Therefore it is good to keep R11's hands as busy as possible with table top activities and involve him in activities and interactions as much as possible. R11 has a history of PICA and has a habit of chewing things (i.e. shirts, bedding, blanket, etc.) so please monitor him carefully for mouthing any objects/clothing/bedding, swallowing any inedible, and when using small objects for activities. Please make sure to track any PICA, chewing, or nose stuffing, or any other unusual behaviors of baseline concern on the baseline sheets to be submitted to clinical services department. Record review of all baseline behavior tracking for R11 noted a PICA incident in July 2014, and an incident in July 2015. All other record review of the baseline behavior tracking did not include any documentation of any maladaptive behavior for R11 but has a written statement on the bottom of the form to be aware of R11 putting inedible items in his mouth. During observations on 10-6-15 at 11:35 A.M., staff were preparing the meal by placing Styrofoam cups and plates on the table. R11 was observed at 11:43 A.M. to be mouthing/chewng the Styrofoam cup. R13 said to R11 that he was not supposed to do that. R11's Styrofoam cup had a missing piece where it was being mouthed at by R11. Facility staff did not monitor R11 when	Z9999		

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Z9999	Continued From page 6	Z9999		

he placed the Styrofoam cup into his mouth. At 11:45 A.M., R11 was observed to be fed his sandwich by E15 (Direct Support Person/DSP). Per record review R11 is to be monitored during mealtimes.

Per interview with E9 (DSP) on 10-6-15 at 12:00 P.M., when asked why does R11 has a Styrofoam cup and paper plate if he has a history of PICA; E9 replied we feed him and he is not supposed to have that.

Per interview with E7 (Qualified Intellectual Disability Professional/QIDP) on 10-6-15 at 12:10 P.M. when asked if R11 was supposed to have a Styrofoam cup and plate if he has a history of PICA, E7 stated she was not sure and that she will pose the question and find out. E7 observed the table R11 was dining at and saw that R11's Styrofoam paper cup was torn and missing from where R11 had put his mouth on it.

During observations on 10-7-15, this surveyor observed R11 from 10:30 A.M. to 12:00 P.M. At 10:55 A.M. R11 was observed pulling on his adult brief and putting the torn piece into his mouth and swallowing it. At 11: 29 A.M., R11 was observed again to pull on his adult brief and put it into his mouth swallowing it. At the time of this incident, R13 was observed stating that R11 was chewing on paper. Facility staff at day training did not supervise R11 when he pulled on his adult diaper brief and put it into his mouth. Facility staff were setting up for lunch at 11:00 A.M. Per record review R11 is to be carefully monitored during mealtimes.

Per interview with E9 (DSP), on 10-7-15 at 12:00 P.M., when asked what is around R11's waist, E9 stated that is his diaper. When asked how do you

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Z9999	Continued From page 7	Z9999		

monitor R11 for his PICA, E9 stated "I'm not sure. I don't have his paperwork. I know he can't have Styrofoam". When asked what are you to do if he puts his thumb into his mouth, E9 replied we usually tell him to take his thumb out of his mouth. What are you to do if he rips his adult diaper brief and puts it into his mouth, E9 replied that " I have not seen him do that". When asked where are his baseline tracking sheets, program goals, or paperwork for R11, E9 stated "I don't have any of his paperwork from goals to tracking sheets. I am not sure why the qualified intellectual disability professional did not provide us with the paperwork".

Per the Intervention Plan for R11 dated 10-8-15, R11 has incidents of engaging in PICA behaviors eating Styrofoam, clothing, and adult brief material. Staff need to have R11 in constant eyesight through out the day to prevent his access to these and other inedible items. During general activities R11 should be constantly supervised to ensure that he does not have access to inedible items. If the assigned staff has to leave the unit, they should make another staff aware to ensure supervision is maintained. If R11 is found to be engaging in PICA staff are to immediately intervene and take the item away from R11. They are to ensure that his adult brief is under his clothes and during meals he is to be provided with plastic cups and plates. Staff are also to track any incidents on the baseline behavior tracking form in his group book.

Per interview with E8 (QIDP) on 10-7-15 at 12:05 P.M., R11 is to be monitored closely however there is no special monitor per say. When asked where staff are to document R11's behavior, E8 stated that he has a baseline tracking sheet in the group book with his goals and sensory program

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Z9999	Continued From page 8	Z9999		

to keep him occupied.
Asked E8 to show where the documentation was for day training/DT and E8 acknowledged that DT did not have the paperwork for R11. When asked what is his behavior plan, E8 stated R11 does not have a formal behavior program. When asked what is R11's PICA, E8 stated that it is a baseline tracking sheet and that E2 (Director of Social Services) collects that information. E8 stated R11 chews on his shirt but stated that there is no evidence that he eats them. E8 stated the chewing on his shirt is a habitual behavior that is not being baseline. When asked what are the programs for R11's behavior, E8 replied that there is no data on him ingesting or chewing on his shirt.
When asked what about him tearing his adult diaper brief, E8 stated, "I have not heard of him chewing on his diaper".
When asked where staff is to document R11's programs, E8 stated in the baseline tracking sheet and that there is not one for October 2015 and that she will put one in the group book. E8 stated that she is not in charge of the day training and that E7 (QIDP) is in charge of day training. E8 stated that they do not have behavior staff doing a baseline sheet that reviews R11's behavior. E8 stated that she does not know what E7 does with the books.

Per interview with E7 on 10-7-15 at 12:20 P.M., regarding R11's baseline tracking sheets, E7 stated "that you would have to find out from his QIDP, E8. E7 stated that she did not have any baseline tracking sheets and that R11 is not on her case load. When asked what do staff have for R11's behavior at this time, E7 stated that she does not have a behavior program for staff to track at this stage for R11. When asked what is the paperwork at day training for R11, E8 stated

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Z9999	Continued From page 9 "right now I do not have anything for him". 2) Per the Physician Order Sheet dated 9-15-15 to 10-14-15, R12 functions in the Moderate Range of Intellectual Disability. R12's diagnoses includes Difficulty Walking / Gait Disorder and General Muscle Weakness. R12 has bilateral heel protectors while in the wheelchair, and to support feet on a pillow when positioned in the wheelchair. Per the Injury/Illness Report dated 7-17-15, observed R12's baby toe noticed teeth bite marks under 4th toe open skin. The record review states the cause of the injury was another resident (R11) had bitten R12. Per Nurses Progress notes dated 7-17-15, R12 was brought to nurses station, report was bite on right foot baby toe by another resident (R11). Observed site noted right foot baby toe and 4th toe with teeth marks under 4th toe, an open site 3 centimeters cleansed with soap and water imprint present. Notified Physician and ordered to send to hospital for evaluation. Per the Incident report dated 7-21-15, separated residents, R12 sent to the emergency department for evaluation. No bruising or swelling noted today 7-21-15. Possible minor fracture of toe but hospital notes it may be due to osteoporosis. R11 was immediately moved to a higher functioning client area and was to have three foot separation from peers until the interdisciplinary team determines best further action. R11's bedroom was changed. The progress note is written as follows: R11 was brought to the great room by staff can't explain what caused the behavior. Residents were	Z9999		

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Z9999	Continued From page 10	Z9999		

watching television and staff E36 (DSP) heard resident scream. E36 turned to look and saw the aggressor with the resident foot in their mouth. E36 ran over to them took resident foot out of the aggressor mouth looked at resident foot and immediately took client to nurse.

Per the peer to peer notification dated 7-17-15, E36 (DSP) heard R12 scream, when she turned around R11 had R12's right foot in his mouth. Both residents were immediately separated. R12 taken to nurse on duty to be examined. Prior to incident both residents were calmly sitting in commons area watching television. Red abrasion on R12's right baby toe area. R12 was taken to emergency department for further assessment. R11 has been transferred to another area of the facility around more highly functional residents. This incident has been documented in R11's behavior tracking file.

Per R12's Hospital Imaging Report dated 7-17-15, there is a metatarsus varus and hallux valgus. There is a fracture of the fifth proximal phalanx with mild valgus angulation. Lucency along the fifth middle phalanx. Fractures not excluded. No additional fracture noted. The impression is a fracture of the fifth proximal phalanx with mild valgus angulation. The report questions a non displaced fracture of the fifth middle phalanx.

Per interview with E3 (Director of Nursing/DON), when asked why was R12 sent to the emergency department, E3 stated R12 had imprint teeth marks on her toe.

Per the Individual Habilitation Plan dated 7-21-15, R11 has Profound Intellectual Disability, Chronic Constipation, Cerebral Palsy, Congenital Spine,

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Z9999	Continued From page 11 Bilateral Hip Dislocations, and PICA. The team meeting narrative summary is to review interventions implemented following the incident in which R11 inflicted an injury upon another peer (R12). The motivation for the incident is unclear, as R11 is not typically a physically aggressive person. R11 does have a diagnosis of PICA and it is unclear whether this condition plays a role in the incident in some way. R11 has had his room and group changed in order to provide him a different peer environment. He appears to have made a satisfactory adjustment to these changes. For a few days following this incident, staff were requested to keep some space between R11 and other residents so as to be out of their direct physical proximity and to monitor R11's behavior closely. No attempts or aggressive inclinations were noted during this period. Staff were retrained on R11's base line data collection procedure and to monitor and record any aggressive behavior or attempts in addition to previous base lined behaviors. R11's QIDP is implementing an individualized sensory program for R11 in order to provide him with preferred sensory activities and decrease the likelihood of maladaptive behaviors. Per interview with E2 (Director of Social Services) dated 10-7-15 at 3:05 P.M. when asked how did staff monitor R11 when he had R12's foot in his mouth, E2 stated that generally R11 should be under visual supervision. E2 stated that he is under visual sight. When asked how do staff monitor his PICA, E2 stated that he is on visual supervision and staff complete baseline tracking sheets if they observe it and intervene if they see it to determine patterns and trends. When asked what was his supervision at the time of the incident, E2 stated that the incident	Z9999		

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Z9999	Continued From page 12	Z9999		

occurred in the great room and that she did not know what his supervision was at the time of the incident.
When asked who were the staff involved, E2 stated that she can't say who the other staff was, except for the staff that wrote the incident. E2 stated if staff were asked for statements, they would most likely be attached to the incident report.
When asked what was the facility conclusion to this incident, E2 stated " I don't think it was determined".
When asked what are his baseline data tracking behaviors, E2 stated that R11 was admitted to the facility on January 2014 with the diagnoses of PICA. When asked for all reports and investigations for the incident on 7-17-15, E2 stated she was sure that this was the extent of it. When asked for staff statements, E2 replied this is what we have.
When asked if there were any client statements, E2 stated that they probably would not be able to give one. When asked if the facility knew what clients were in the room during this incident, E2 replied no, but that can give a general guess.
When asked what is the monitoring status for R11, E2 stated it is visual supervision in common areas. When asked what is the data, E2 stated that it is difficult to create a program when the tracking sheets are blank. E2 stated that the QIDP's are working on it and that the behavior contract has changed.
When asked what the reason was for R11's DT services being changed. E2 stated that he went to a DT, but they sold the building and so R11 has been at the facility for DT since April 2015. When asked how many attempts of PICA has he had at this facility, E2 stated that she could not give an answer. When asked how is R11 supposed to be monitored in the great room, E2 replied that he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	10/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z9999	Continued From page 13	Z9999		

still should be under staff visual supervision when he wheels himself from one area to another, such as the great room. .

During observations on 10-7-15 at 10:15 A.M., R11 was observed moving himself in his wheelchair into the Great Room DT. R11 was transferred with staff assistance to a table to sit next to R4. R4 was sitting in a wheelchair with her feet up, only wearing socks. Facility staff were noted to change the socks of R4. R11 was sitting next to R4 without staff supervision, with her feet elevated within arms length of R11.

Per the Individual Service Plan dated 5/2015, R4 functions in the Profound Range of Intellectual Disability. R4's diagnoses includes Cerebral Palsy, Brittle Bones, Spina Bifida.

Per interview with E9 (DSP) on 10-8-15 at 12 P.M., R11 has to have visual supervision kept on him every 15 to 20 minutes. E9 stated that R11 eats paper things. E9 stated that she was unaware of any physical aggression that R11 hurt any other residents.

Per interview with E14 (DSP) on 10-8-15 at 12 P.M., R11 likes to grab things and put them into his mouth and that he should be in close contact supervision every 15 to 20 minutes. E14 stated that R11 can sit close to other residents and is unaware of R11 hurting any other residents. E14 stated that you have to pay close attention to R11.

3b) Injury / Illness Report for R37 dated 7/6/15 reads, "open laceration / tear to [left] side of scrotum over [left] testicle... (has previous [history] of tear to [scrotal] area) - observed during brief change to spasm - staff heard rupture / split sound, observed bleeding to [left] scrotum...

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6007066	A. BUILDING: _____ B. WING _____	10/26/2015

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Z9999	Continued From page 14 Time: 3:30 p.m." Department of Public Health fax report dated 7/6/15 reads, "Emergency Room (ER) eval[uation] of laceration / tear to [left] side of scrotum - observed to spasm during brief change and ruptured scrotal sack (previous [history] of scrotal tear to same area). Not admitted - sutures to [left] scrotum and returned to facility at 8:10 p.m. [with] orders... Goal / Service Objective sheet dated 6/17/15 reads, "Staff will ensure R37 has pillow or leg spacer placed between legs at all times other than when receiving [lower extremities] PROM exercises". The sheet notes Target Completion Date as "ongoing", Person Responsible as "Facility staff, all shifts and Day Training (DT) staff". Medical Comprehensive Functional Assessment dated 6/17/15 reads, "Positioning devices: chest strap Other: ...pillow between knees to protect scrotum from pressure (when not in [wheelchair]) Other Concerns / Recommendations:...3. At risk for skin breakdown (stable) - [history] of reoccurring scrotal irritation ([due to] enlarged scrotum becoming wedged between thighs - use pillow between knees / legs when not positioned in [wheelchair]..." On 10/13/15, at 11 a.m., R37 was observed without pillow between his legs and his knees were tightly together. On 10/13/15, at 11:05 a.m., when asked whether a pillow is placed between his legs, E28 (DSP) stated she "worked with him for 2 months. He's repositioned every hour. I sometimes put a pillow between legs because his legs are squeezed together."	Z9999		

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BELLWOOD DEVELOPMENTAL CENTER	105 EASTERN AVENUE BELLWOOD, IL 60104

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Z9999	Continued From page 15 R37's record did not include investigation or corrective action after the incident on 7/6/15 where he had a scrotal tear that resulted in sutures at the ER. The Public Health fax report stated that R37 has a history of scrotal tear; however, no further information was provided in the report on when the scrotal tear happened in the past. Both the public health fax report and Injury report did not give information on investigation on previous occurrence (how it happened in the past). No investigation was done to see if anything can be done to prevent future scrotal tear for R37, such as, is the wheelchair safe? does he need to wear the pillow between his knees / legs all the time? should spasticity medication be looked into? On 10/7/15, at 11:30 a.m., E3 (DON) stated that she was there when the R37's incident on 7/6/15 occurred. E3 confirmed that she did not conduct an investigation because it was not an unknown injury. On 10/8/15, at 11:30 a.m., E2 confirmed that an investigation should have been done on how to prevent future injury for R37. 4) Record review includes a form titled "(name of facility) Rights Restrictions" dated 5/11/15 which states "R27 admitted to (name of facility) in 12-2014 due to need for more supervision and medication monitoring. R57 had moved from an apartment in the Intermediate Care Facility setting due to multiple hospitalizations from falls and uncontrolled seizures. A Physical Therapy assessment was done with recommended independent transfer, but stand by assistance with ambulation. An assist rail was provided for R27 on his bed, and handrails in his bathroom.	Z9999		

Illinois Department of Public Health

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	IL6007066	A. BUILDING: _____ B. WING _____	10/26/2015

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Z9999	Continued From page 16 R27 experienced two falls without injury due to seizure activity. Falls have increased without injury. The resident has stated that he can transfer himself and will not wait for staff to assist him. A new Physical Therapy assessment was done with recommendation he have stand by assistance when transfering to the bathroom. He reported he was falling when he stops to adjust his clothing. A toileting schedule every two hours was implemented to ask and assist him to the bathroom. This was effective for a short time but he went back to not waiting for staff assist." "An alarm seatbelt is being sought for this resident 's wheelchair to alert staff to his need for stand by assistance." Record review of the incident reports were conducted on 10/5/15, the following was recorded by the facility: Incident #1, 7/4/15 at 1:00pm, R27, "resident sitting on side of his bed to use his urinal and slide down." "upon entering participant's room he was sitting on the floor next to his bed. Staff assisted participate back in his chair." Incident #2, 8/12/15, R27, "found on floor in sitting position near bed." Incident #3, 9/10/15, R27, "client came to nurse's station stating he fell in his bathroom and hit the back of his head on the sink then the floor." Incident #4, 9/16/15, R27, unwitnessed, "client states he fell out of bed on his back." "staff reported client fell assessed client states he got out of wheelchair to fix his bed and fell on back." "no injury."	Z9999		

Illinois Department of Public Health

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Z9999	Continued From page 17	Z9999		

Incident #5, 9/22/15, R27, " fell out of his wheelchair, missed it after toileting, rolled on floor causing his back going out." "no injury."

Incident #6, 9/28/15, R27, "per client, he was trying to get out of bed to go to the bathroom by himself and he rolled on the floor. Client reminded to ask for help." "complained of back discomfort. Tylenol 650mg given. No injury noted." "Talked with R27 and refused any additional assistance even though history of falls."

Incident #7, 10/2/15, R27 "states he was coming to the bathroom by himself and he came out he fell reminded client to ask for assistance."

Incident #8, 10/6/15, R27, "every 15 minute checks started. Fall in bathroom, transferring from commode to wheelchair." "I hit the back of my head on wall when I fell."

An interview was conducted with E1, (Acting Administrator), on 10/7/15 at 12:07pm and again on 10/8/15 at 3:35pm regarding R27's multiple falls. According to E1 the facility is aware that R27 has the potential to fall and states the facility has given R27 a urinal so he doesn't get up and fall, we changed his room and "the chair alarm". E1 did state that R27 is not compliant with the wheelchair alarm and "he is his own guardian" and that the facility does not have a safety plan in place to prevent future falls but a 15 minute checks were started. E1 was asked if an assessment such as a functional assessment had been conducted to assess R27's understanding of risks associated with his falls. There was not evidence presented that this was done.

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Z9999	Continued From page 18 An interview was conducted with E3, DON on 10/8/15 at 2:45pm regarding the multiple falls of R27. E3 states she started a tracking system for R27, surveyor noted that only 3 falls were entered on her spreadsheet. E3 confirmed that there is not a specific staff that is analyzing the data for the falls. An interview was conducted again with E1 on 10/9/15 at 10:50am, E1 states that "the facility have a program for a safety plan that was put together yesterday." An interview was conducted with E3, (DON) on 10/9/15 at 10:50am. E3 states, "he is inconsistent with compliance with the chair alarm." An interview was conducted with E12, QIDP on 10/9/15 at 10:10am, according to E12 safeguards the facility have put in regarding the above falls are the chair alarm and the supervision level but when asked about details of the supervision level stated the supervision level is the same but the staff watch him closer. E12 did state R27 is not compliant with the wheelchair alarm. E12 was not able to show evidence of a safety plan for R27." An interview was conducted with R27 on 10/15/15 at 11:20am regarding the above falls. R27 states, "yes I fall a lot, I have always fallen. I fell a lot at the other place I came from and I will probable fall again, you see I was born with cerebral palsy and my whole left side is weak, I can't use this left side, so I fall sometimes." R27 was asked if he injured himself when he falls, yeah I hurt myself a couple times but I mean what am I gonna do." The facility failed to show evidence of) client or staff interviews after the falls, b) what action was taken to manage and resolve the incident as	Z9999		

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Z9999	Continued From page 19	Z9999		

required by their incident report form, c) if agency policy was followed, if a behavior program was implemented, whether a special team meeting was requested after the falls, if team discussion took place regarding the 9/10/15 incident where R27 states he hit his head on the sink and the floor but refused any treatment, or whether patterns were being tracked for this individual.

E1 (Acting Administrator) stated on 10/8/15 at 10:30 am, that there is no reproducible documentation that trends and patterns are reviewed for incidents. He said he just came to this facility about 1 month ago, and is not aware of a process to monitor patterns and trends.
E2 (Director of Social Services) stated on 10/14/15 at 9:30am that there used to be meetings to discuss patterns and trends, but these meetings haven't taken place in approximately over 1 year.

(B)